State of Utah
Department of Human Resource Management

NOTICE OF INTENTION TO RETURN FROM LEAVE

Name of Employee: _____

Name of Supervisor: _____

Agency/Dept: _____ Division: _____

Start Date of FMLA Leave: _____ Expected Return Date: _____

I understand that my restoration to employment is subject to the following conditions:

1. If leave is for an employee's illness, as a condition of restoration, each employee must provide a written certification from his/her health care provider that he/she is able to resume working.

2. Every attempt will be made to restore employee returning from leave to his/her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits.

3. An employee returning from family and medical leave shall not be entitled to the accrual of any seniority or employment benefits during the period of leave. If the leave taken was leave without pay (LWOP).

Employee's Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROVIDER.

I have examined _____ and certify that he/she is fully able to resume working.

Health Care Provider's Signature: _____ Date: _____